APPLICATION FOR THERAPEUTIC FOSTER FAMILY HOME LICENSE

INSTRUCTIONS: Include the full name of all persons living in your home at present. For further entries, use the reverse side of this form. Complete this form and return to:

TFC Program Coordinator
Lutheran Child and Family Services of IN/KY
1525 N. Ritter Ave. Indianapolis, IN 46219
OR Fax to 317-322-4085

*Your Social Security number is being requested by LCFS in accordance with IC 4-1-6-1. Disclosure is mandatory, and this form cannot be processed without it.

FULL NAME	**DATE OF BIRTH**	**SOCIAL SECURITY NUMBER***	**PLACE OF BIRTH**	**RELATION TO FAMILY**	**OCCUPATION OR SCHOOL GRADE**	**NAME OF EMPLOYER**
Applicant A						
Applicant B						
Children						
Others						

<table>
<tr><td colspan="7">Present Address (number and street, city, state, and ZIP code)</td></tr>
<tr><td colspan="7">Directions to home:</td></tr>
<tr><td>Telephone number-
home (   )</td><td colspan="2">Work #
(   )</td><td colspan="2">Email Address:</td><td colspan="2">Age and sex of children for whom you want to provide care:</td></tr>
<tr><td colspan="7">Reasons for wanting to care for children in need of services:</td></tr>
<tr><td colspan="7">Have you ever applied for a foster family home license? If Yes, from Whom?
□Yes □No</td></tr>
<tr><td colspan="7">Have you ever cared for/ fostered a non-related child? If Yes, please explain:
□Yes □No</td></tr>
<tr><td colspan="2">How many children do you have of your own?
Applicant A ______________
Applicant B ______________</td><td colspan="2">Family Income per month: $</td><td colspan="3">Religion
Applicant A ________________________________
Applicant B ________________________________</td></tr>
<tr><td>Place of marriage</td><td colspan="2">Date of marriage</td><td colspan="2">Number of rooms in your home</td><td>Do you have a yard?
□Yes □No</td><td>Race
Applicant A _____
Applicant B _____</td></tr>
</table>

APPLICATION FOR THERAPEUTIC FOSTER FAMILY HOME LICENSE (CONTINUED)

Please give, as references, the names of your physician and 4 persons (non-relatives) who know your family life.			
NAME	**ADDRESS**	**CITY, STATE, ZIP**	**TELEPHONE NUMBER**
NAME OF PHYSICIAN			

Other states applicant has resided in:
If applicant has been named in any CPS reports as having committed any act of child abuse/neglect as determined by the Department of Children's Services, this may be grounds for revocation or denial of a license.
Has applicant been named in any substantiated cases of child abuse and neglect as determined by the Department of Children's Services? □No □Yes If yes, what year?___________________________
I certify that all statements made in this application, and any attachments thereto, are correct to the best of my knowledge. I understand that any information, written or verbal, given by a reference is confidential and cannot be reviewed by the applicant. For adoptive applicants residing in counties which administer an adoption fee plan, I understand that, according to Chapter 113, Acts of 1969, the county may charge a placement and/or home study fee.

Signature of Applicant A	Date signed (month, day, year)
Signature of Applicant B	Date signed (month, day, year)

Use for additional entries from first page, if required: